

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05914

05914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Patuxent River</b>				c. LENGTH OF STAY IN 1b <b>18-1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NAS, Station Hospital</b>				d. STREET ADDRESS <b>272 Three Notch Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Benjamin</b> Middle <b>F.</b> Last <b>Aud Sr.</b>				4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>12-2-89</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months <b>76</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POST MASTER</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>BENJAMIN IGNATIUS AUD</b>				14. MOTHER'S MAIDEN NAME <b>Julia BROWN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-32-2042</b>		17. INFORMANT <b>MRS IRENE M. AUD</b>		Address <b>SAME AS # 2 ABOVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Myocardial Infarct</b> <b>4301</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. } DUE TO (c) }						INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>1210 P</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Frank J. Konicek</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4-28-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. J. KONICEK LT MC USNR</b>				22d. ADDRESS <b>Same as #1</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 30, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. GEORGE CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>VALLEY LEE, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. CLARKE MATTINGLEY</b>				ADDRESS <b>LEONARDTOWN, MARYLAND</b>			
25a. REC'D BY REGISTRAR <b>MAY 4 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

W. CLARK BATTINLEY LEONARDTOWN, MARYLAND  
MAY 1 1966  
APRIL 30, 1966 ST. GEORGE CEMETERY VALLEY LEE, MARYLAND

*Frank J. [unclear]*

CL-10-2042 MR. IRVING M. AND  
SARAH AS F. ABOVE

BENJAMIN I. WATKINS AND  
BORN

PORT WATKIN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

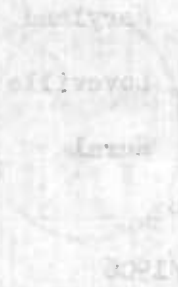
VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05915 CERTIFICATE OF DEATH 05912											
1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtomm</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Loveville</b>				d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Marys Hospital</b>						d. STREET ADDRESS <b>Rural</b>					
3. NAME OF DECEASED (Type or print) First <b>DANIEL</b> Middle <b>JEFFERSON</b> Last <b>BOWLES</b>						4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>19 66</b>					
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/5/1906</b>		9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William A. Bowles</b>						14. MOTHER'S MAIDEN NAME <b>Rena Lassiter</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Mary E. Bowles - same as # 2</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>Diabetes mellitus.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>  <b>10 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>8-8</b> , 19 <b>63</b> , to <b>3-26</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3-26</b> 19 <b>66</b> , and that death occurred at <b>P</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>John F. Fenwick</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/3/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>John F. Fenwick, M.D.</b>						22d. ADDRESS <b>Leonardtomm, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/6/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Morganza, Maryland</b>					
24. FUNERAL DIRECTOR <b>P.B. Robinson - Leonardtomm, Md.</b>						25a. REC'D BY REGISTRAR <b>APR 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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05916

## CERTIFICATE OF DEATH

05913

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CALLAWAY</b>			c. LENGTH OF STAY IN 1b <b>LIFE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CALLAWAY</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>AUDREY MARGUERITE BRISCOE</b>				4. DATE OF DEATH Month Day Year <b>APRIL 9, 1966</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 3, 1965</b>		9. AGE (In years last birthday) yrs. <b>5</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>5 6</b>	IF UNDER 24 HRS. <b>6</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE JOSEPH EDISON</b>				14. MOTHER'S MAIDEN NAME <b>KATIE BRISCOE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>KATIE BRISCOE</b> Address <b>SAME AS #2 ABOVE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Whooping cough</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>3 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 7, 1966</b> , to <b>April 9, 1966</b> , that (I) (we) last saw the deceased alive on <b>April 7, 1966</b> , and that death occurred on <b>7th</b> M, from causes on and on the date stated above.							
22a. SIGNATURE <b>[Signature]</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>April 11/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>P. J. B. FAX, M.D.</b>				22d. ADDRESS <b>Great Mills Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 11, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. ALOYSIUS</b>		23d. LOCATION (City or Town) (County) (State) <b>LEONARDTOWN, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>				ADDRESS <b>LEONARDTOWN, MD.</b>		25. REC'D BY REGISTRAR <b>APR 15 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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UNITED STATES

1961



ST. LOUIS, MO.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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05917

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05914

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admision) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>				c. LENGTH OF STAY IN 1b <b>7 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>ST. MARY'S HOSPITAL</b>				d. STREET ADDRESS <b>BRANDYWINE</b>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ALENE</b> Last <b>CAYWOOD</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>13</b> Year <b>19 66</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 23, 1918</b>	
9. AGE (In years last birthday) <b>48 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JODY QUADE</b>		14. MOTHER'S MAIDEN NAME <b>FRANCES WILLIAMS</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>EVANS CAYWOOD</b>		Address <b>SAME AS # 2 ABOVE</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Hypertension</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Apr 7, 1966</b> , to <b>Apr 13, 1966</b> , that (I) (we) last saw the deceased alive on <b>Apr 13, 1966</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Leon W. Berube</b>				22b. DATE SIGNED <b>APR 18 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>LEON W. BERUBE M. D.</b>	
22d. ADDRESS <b>MECHANICSVILLE, MARYLAND</b>				22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 16, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHRIST CHURCH CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>CHAPTICO, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>				25a. ADDRESS <b>LEONARDTOWN, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>	

LAINE BATTISLEY LEONARDTOWN, MARYLAND

SERIAL

APRIL 10, 1966 CHRIST CHURCH CEMETERY

CHARLOTTE, MARYLAND

LEON H. BERRY, JR.

MICHAELVILLE, MARYLAND

NO

NONE

EVANS DAYWOOD

DANIELA

EVANS

JOHN DODGE

FRANCIS WILLIAM

HOUSE WIFE

MARYLAND

FEMALE WHITE

FEB. 23, 1912

WIFE

EVANS

DAYWOOD

APRIL 1, 1966

ST. MARY'S HOSPITAL

7 DAYS

BRANDYVILLE

LEONARDTOWN

ST. MARY'S

MARYLAND

100319



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

M

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Piney Point</b>			c. LENGTH OF STAY IN ID		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Valley Lee</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rural</b>					d. STREET ADDRESS <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>GEORGE</b>			First <b>IGNATIUS</b>		Last <b>CECIL</b>		4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>19 66</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/21/1907</b>		9. AGE (In years last birthday) <b>59</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>George B. Cecil (dec)</b>					14. MOTHER'S MAIDEN NAME <b>Annie M. Raley (dec)</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>215 38 3389</b>		17. INFORMANT <b>Margaret C. Dean - same as # 2</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>9121</b> <b>Intra Thoracic Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>immed</b> (b) <b>DUE TO</b> (c) <b>DUE TO</b>								INTERVAL BETWEEN ONSET AND DEATH <b>immed</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>was driving a tractor which over turned</b>							
20c. TIME OF INJURY Month, Day, Year Hour <b>4:00</b> a.m. <b>p.m.</b> <b>4:20</b> <b>19 66</b>			20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>on farm</b>		20f. (City or town) (County) (State) <b>Piney Point, St. Marys, Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>W.D. Boyd</b>			M.D. <b>Leonardtown, Maryland</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED <b>4/21/66</b>		
EXAMINER'S NAME (Type) <b>Wm. D. Boyd,</b>			M.D. <b>Leonardtown, Maryland</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>4/23/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. George's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Valley Lee, Maryland</b>			
24. FUNERAL DIRECTOR <b>P.B. Robinson</b>					ADDRESS <b>P.B. Robinson - Leonardtown, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 25 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05919 CERTIFICATE OF DEATH 05916											
1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ridge</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ridge</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rural</b>						d. STREET ADDRESS <b>Rural</b>					
3. NAME OF DECEASED (Type or print) First <b>MILDRED</b> Middle <b>REGINA</b> Last <b>DEAN</b>						4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>19 66</b>					
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/27/1949</b>		9. AGE (In years last birthday) <b>16</b> yrs.		IF UNDER 1 YEAR Months <b>12</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank W. Dean</b>						14. MOTHER'S MAIDEN NAME <b>Frances R. Wise</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Frank W. Dean - same as # 2</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 500 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Acute bronchitis</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebral palsy</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April 20, 1966</b> , to <b>April 21, 1966</b> , that (I) (we) last saw the deceased alive on <b>April 20, 1966</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>P.J. Bean</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/21/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>P.J. Bean, M.D.</b>						22d. ADDRESS <b>Great Mills, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/23/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Ridge, Maryland</b>			
24. FUNERAL DIRECTOR <b>P.B. Robinson</b> ADDRESS <b>P.B. Robinson - Leonardtown, Maryland</b>						25a. REC'D BY REGISTRAR <b>APR 25 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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1998 • J. Neurosci., November 11 • 18(23):9601–9610 • 9605

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05920 CERTIFICATE OF DEATH 05917									
1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>ST. MARY'S HOSPITAL</b>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGUERITE</b> Middle <b>ABELL</b> Last <b>DUKE</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>25</b> Year <b>1966</b>						
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 31, 1887</b>		9. AGE (In years last birthday) <b>79</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECTARY</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>BANK</b>			11. BIRTHPLACE (County & State, or foreign country) <b>LEONARDTOWN, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ENOCH BOOTH ABELL</b>					14. MOTHER'S MAIDEN NAME <b>KATHERINE CAMALIER</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <b>216-14-3290</b>		17. INFORMANT <b>CLINTON B. DUKE LEONARDTOWN, MARYLAND</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X Bronchial Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Cardiac failure</b> (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1/15</b> , 19 <b>56</b> , to <b>4/25</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4/25</b> , 19 <b>66</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Charles Greenwell</b>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/26/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>CHARLES GREENWELL M. D.</b>					22d. ADDRESS <b>LEONARDTOWN, MARYLAND</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>APRIL 27, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. ALOYSIUS</b>		23d. LOCATION (City, town or county) (State) <b>LEONARDTOWN, MARYLAND</b>		
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>					25a. REC'D BY REGISTRAR <b>APR 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
05921			
05918			
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b> c. LENGTH OF STAY IN 1b <b>5 HRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>ST. MARY'S HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL SCOTLAND</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>LORETTA</b> Last <b>EDDY</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>18</b> Year <b>19 66</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 27, 1887</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>WILLIAM F. KENNY</b>		14. MOTHER'S MAIDEN NAME <b>GUIANA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT <b>MADLINE K. TULLIS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory Collapse</b> 5400 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarction</b> (c) <b>Peptic Ulcer</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 min</b> <b>1 day</b> <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic C-V Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/16</b> , 19 <b>66</b> to <b>4/18</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>4/18</b> , 19 <b>66</b> and that death occurred at <b>10:15</b> M. from the causes and on the date stated above.			
22a. SIGNATURE <b>James P. Jarboe</b>		22b. DATE SIGNED <b>4/20/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES P. JARBOE M. D.</b>		22d. ADDRESS <b>GREAT MILLS, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/21/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>EBENEZER</b>		23d. LOCATION (City, town or county) (State) <b>GREAT MILLS MD.</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>		25. REC'D BY REGISTRAR <b>APR 21 1966</b>	
25a. ADDRESS <b>LEONARDTOWN, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

W. CLARK BATTINLEY LEONARDTOWN, HAWKLAND

4/21/66

MEMBER

REAR HILL

GREAT HILL, HAWKLAND

JAMES F. BARBOE M. J.

ADOLPH A. TULL

ILLIAN F. KENNY

HOUSE WIFE

FEMALE WHITE

JULY 27, 1957

BOOY

L. BETTA

MARY

ST. MARY'S HOSPITAL

LEONARDTOWN

MRS. J.

RURAL

SCOTLAND

ST. MARY'S

HAWKLAND

ST. MARY'S

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05922									
CERTIFICATE OF DEATH									
05919									
1. PLACE OF DEATH a. COUNTY <b>ST. MARYS</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARYS HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARYS</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - HOLLYWOOD</b> d. STREET ADDRESS <b>RT. 1 BOX 229</b>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>BERNARD XAVIER FERGUSON JR.</b>					4. DATE OF DEATH Month Day Year <b>APRIL 7 19 66</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/26/1923</b>		9. AGE (In years last birthday) <b>42</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SERVICE &amp; REPAIR</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>SO. MD. ELEC. COOP</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BERNARD XAVIER FERGUSON SR.</b>					14. MOTHER'S MAIDEN NAME <b>ESSIE MARIE PAYNE</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>			16. SOCIAL SECURITY NO. <b>WW II 217 18 7973</b>		17. INFORMANT <b>MRS. AGNES E. FERGUSON</b>			Address <b>SAME AS #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>4-7</b> , 19 <b>66</b> , to <b>4-7</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4-7-66</b> 19 <b>66</b> , and that death occurred at <b>10:34 A.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>W.H. Patrick</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> M.O. <input type="checkbox"/> 22d. ADDRESS <b>LEXINGTON PARK, MARYLAND</b>			22b. DATE SIGNED <b>4-8-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>WM. H. PATRICK M.D.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/11/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHNS CEMETERY</b>			23d. LOCATION (City, town or county) (State) <b>HOLLYWOOD, MARYLAND</b>		
24. FUNERAL DIRECTOR <b>P.B. ROBINSON - LEONARDTOWN, MARYLAND</b>					25a. REC'D BY REGISTRAR <b>APR 11 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
05923 CERTIFICATE OF DEATH 05920														
1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Indian Head</b>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Marys Nurseing Home</b>					d. STREET ADDRESS <b>Rural</b>									
3. NAME OF DECEASED (Type or print) First <b>Virginia</b> Middle <b>Gertrude</b> Last <b>GREGOVSKY</b>					4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>1966</b>									
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10 / 6 / 1892</b>		9. AGE (In years last birthday) <b>73</b> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>						
13. FATHER'S NAME <b>Wm. Joseph Ambrose (dec)</b>					14. MOTHER'S MAIDEN NAME <b>Marie F. Jenkins (dec)</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>					16. SOCIAL SECURITY NO. <b>579 32 9267</b>		17. INFORMANT <b>Mrs. Marie Clements - California, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Renal insufficiency</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Renal insufficiency</b>								INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>						
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 2, 1965</b> to <b>April 1, 1966</b> , that (I) (we) last saw the deceased alive on <b>March 31, 1966</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above.														
22a. SIGNATURE <b>P.J. Bean</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>4/1/66</b>						
22c. PHYSICIAN'S NAME (Type) <b>P.J. Bean, M.D.</b>					22d. ADDRESS <b>Great Mills, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/5/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>							
24. FUNERAL DIRECTOR <b>P.B. Robinson - Leonardtown, Maryland</b>					25a. REC'D BY REGISTRAR <b>APR 5 1966</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 05924 CERTIFICATE OF DEATH 05921											
1. PLACE OF DEATH a. COUNTY <u>St. Marys</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Marys Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Truman Commodas Hancock</u>				4. DATE OF DEATH Month Day Year <u>April 29 1966</u>							
5. SEX <u>M.</u>		6. COLOR OR RACE <u>Can.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 14, 1887</u>		9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>James Donald Hancock</u>				14. MOTHER'S MAIDEN NAME <u>Mary Charlotte Thompson</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-367481</u>		17. INFORMANT <u>Carroll Hancock</u> Address <u>Hughesville Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple myeloma</u> 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12-16</u> , 19 <u>64</u> , to <u>April 29</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>April 29</u> , 19 <u>66</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Roy Guyther</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/29/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Roy Guyther M.D.</u>				22d. ADDRESS <u>Mechanicsville, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 2, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Old Fields</u>		23d. LOCATION (City, town or county) (State) <u>Hughesville, Md.</u>					
24. FUNERAL DIRECTOR <u>The Hunt Funeral Home, Waldorf, Md.</u>				ADDRESS		25a. REC'D BY REGISTRAR <u>MAY 5 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1898

THE UNIVERSITY OF CHICAGO  
LIBRARY

1898

James David Hancock  
Formerly of the  
U.S. Army

James David Hancock  
Formerly of the  
U.S. Army  
1898

James David Hancock  
Formerly of the  
U.S. Army  
1898

James David Hancock  
Formerly of the  
U.S. Army  
1898

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05925					05922				
1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HOLLYWOOD</b> c. LENGTH OF STAY IN 1b <b>LIFE</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <th colspan="5">2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL HOLLYWOOD</b> d. STREET ADDRESS <b>18-1</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></th>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL HOLLYWOOD</b> d. STREET ADDRESS <b>18-1</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>LEILA</b> First <b>ABELL</b> Middle <b>HANOBECK</b> Last			4. DATE OF DEATH <b>APRIL</b> Month <b>20</b> Day <b>19 66</b> Year						
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 20, 1921</b>		9. AGE (In years last birthday) <b>45</b> yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE CLAUDE ABELL</b>					14. MOTHER'S MAIDEN NAME <b>LEILA CATHERINE WILKINSON</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>MRS LEILA C. ABELL SAME AS # 2 ABOVE</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis of Liver</b> <b>5810</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute gastritis</b> (c) <b>DUE TO</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>5 days</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>April 16, 1966</b> to <b>April 20, 1966</b> , that (I) (we) last saw the deceased alive on <b>April 20, 1966</b> , and that death occurred at <b>1:45 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>P. J. BEAN</b>					22b. DATE SIGNED <b>April 21/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>P. J. BEAN M. D.</b>					22d. ADDRESS <b>GREAT MILLS, MARYLAND</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 23, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. J. HNS</b>			23d. LOCATION (City, town or county) (State) <b>HOLLYWOOD, MARYLAND</b>		
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>					25a. REC'D BY REGISTRAR <b>APR 22 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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BARCLAY

ST. PAUL

APRIL 27, 1955

LIVE

RECORDING

APRIL

HOMER

APRIL

APRIL

MARCH 27, 1955

WHITE

BARCLAY

THE WHITE HOUSE

GEORGE CLAUDE ARTEL

THE WHITE HOUSE

GREAT HILL, CALIFORNIA

ST. PAUL, MINN.

BARCLAY

RECORDING

ST. PAUL, MINN.

APRIL 27, 1955

BURIAL

W. CLARK BATTY, JR., LEONARDTOWN, MARYLAND

APRIL 27, 1955

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>ST. MARYS</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SCOTLAND</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>RURAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARYS</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SCOTLAND</b> d. STREET ADDRESS <b>RURAL</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>QUEENIE</b> Middle <b>VICTORIA</b> Last <b>KRAUS</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>26</b> Year <b>1966</b>						
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/6/1904</b>		9. AGE (in years last birthday) <b>62</b> yrs. IF UNDER 1 YEAR: Months <b></b> Days <b></b> Hours <b></b> Min. <b></b> IF UNDER 24 HRS: Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN A. GATTON (DEC'D)</b>					14. MOTHER'S MAIDEN NAME <b>MARY E. NORRIS (DEC'D)</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>GEORGE J. KRAUS - SAME AS #2</b> Address <b></b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic HD</b> <b>4200</b> DUE TO (b) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b></b>									INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b></b> p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <b></b> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>WM. D. BOYD M.D.</b> Address (Street, city, town, or county) <b>LEONARDTOWN, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>4/30/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. MICHAELS CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>RIDGE, MARYLAND</b>		
24. FUNERAL DIRECTOR <b>P. B. ROBINSON</b> ADDRESS <b>P. B. ROBINSON - LEONARDTOWN, MARYLAND</b>						25a. REC'D BY REGISTRAR <b>MAY 2 1966</b> DATE <b></b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
05927

CERTIFICATE OF DEATH

05924

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b> c. LENGTH OF STAY IN 1b <b>St. Marys Hospital</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Marys Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>St. Marys City</b> d. STREET ADDRESS <b>Rural</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>MARGARET HASTING LANCASTER</b>		4. DATE OF DEATH Month Day Year <b>April 16 1966</b>		5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9 / 29 / 1927</b>		9. AGE (in years last birthday) <b>38</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>George E. Hasting (dec)</b>						14. MOTHER'S MAIDEN NAME <b>Catherine McNulty (dec)</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>221 16 9529</b>				17. INFORMANT <b>Thomas C. Lancaster - same as # 2</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Adenocarcinoma of Breast</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 yrs.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I (this hospital) attended the deceased from <b>4/16/66</b> to <b>4/16/66</b> , that (I) (we) last saw the deceased alive on <b>4/16/66</b> and that death occurred at <b>11 PM</b> , from the causes and on the date stated above.															
22a. SIGNATURE <b>James P. Jarboe</b>										22b. DATE SIGNED <b>4/16/66</b>					
22c. PHYSICIAN'S NAME (Type) <b>James P. Jarboe, M.D.</b>										22d. ADDRESS <b>Great Mills, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4/19/66</b>				23c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Ridge, Maryland</b>			
24. FUNERAL DIRECTOR <b>P.B. Robinson - Leonardtown, Maryland</b>										25a. REC'D BY REGISTRAR <b>APR 21 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION

4/18/66  
Committee  
Recommendation

4/18/66  
J. P. Jones

4/18/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 13, 14 Film G575 4/20/66 mh

05928

CERTIFICATE OF DEATH

05925

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HUGHESVILLE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S HOSPITAL</b>		d. STREET ADDRESS <b>08-2</b>	
3. NAME OF DECEASED (Type or print) First <b>MILLS</b> Middle <b>ALOYSIUS</b> Last <b>MELSON</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>4</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 2, 1890</b>
9. AGE (In years last birthday) yrs. <b>76</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-36-3827</b>	
17. INFORMANT <b>MARY CATHERINE HARRIS</b>		Address <b>HUGHESVILLE, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Congestive heart failure</b> (c) <b>2/2</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002 tuberculosis, pulmonary</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct</b> , 19 <b>57</b> , to <b>Apr</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Apr 3 1966</b> , and that death occurred at <b>7</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>David L. Mossman</b>		22b. DATE SIGNED <b>4/6/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DAVID L. MOSSMAN M. D.</b>		22d. ADDRESS <b>MECHANICSVILLE, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 6, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. ALOYSIUS CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>LEONARDTOWN, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>		25a. REC'D BY REGISTRAR <b>APR 11 1966</b>	
ADDRESS <b>LEONARDTOWN, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05929 CERTIFICATE OF DEATH 05926									
1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>				c. LENGTH OF STAY IN 1b <b>14 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Mechanicsville 12-1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Mary's Hospital</b>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Dorothy</b> Middle <b>Regina</b> Last <b>Pilkerton</b>			4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>19 66</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 14, '21</b>		9. AGE (In years last birthday) <b>44</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Co.</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Pere Peter Smith</b>					14. MOTHER'S MAIDEN NAME <b>Katherine Robinson</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>217-32-1414</b>		17. INFORMANT Address <b>Joseph R. Pilkerton, Mechanicsville</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b> <b>330X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>2 hr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 12, 1966</b> to <b>Apr 12, 1966</b> , that (I) (we) last saw the deceased alive on <b>Apr 12, 1966</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>David L. Mossman</b>					22b. DATE SIGNED <b>4/13/66</b>		22c. PHYSICIAN'S NAME (Type) <b>David L. Mossman M.D.</b>		
22d. ADDRESS <b>Mechanicsville, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>April 15, '66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Memorial Gardens</b>		23d. LOCATION (City, town or county) (State) <b>Waldorf, Charles Md.</b>		
24. FUNERAL DIRECTOR <b>W. Clarke Mattingley, Leonardtown, Md.</b>					25a. RECEIVED BY REGISTRAR <b>APR 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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THE STATE OF TEXAS

COUNTY OF DALLAS

Know all men by these presents

that I, the undersigned

do hereby certify

that the within

is a true and

correct copy of the

original as the same appears

from the records of the

County of Dallas

and is a true and

correct copy of the

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## CERTIFICATE OF DEATH

059227

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>		c. LENGTH OF STAY IN lb <b>4 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL MECHANICSVILLE</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S HOSPITAL</b>		d. STREET ADDRESS <b>RT 2</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>MARY GERTRUDE RIDGELY</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>5</b> Year <b>1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 27, 1898</b>
9. AGE (In years last birthday) yrs. <b>67</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JAMES STOUTEN THOMPSON</b>	
14. MOTHER'S MAIDEN NAME <b>LAURA ESTELLE CHRISTMAN</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>BERNARD N. RIDGELY RT. 2 MECHANICSVILLE, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer</b> DUE TO (b) <b>Intestinal obstruction</b> DUE TO (c) <b>Ovarian Cancer</b>			INTERVAL BETWEEN ONSET AND DEATH <b>245</b> <b>1 yr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct</b> , 19 <b>57</b> , to <b>Apr 5</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Apr 4</b> , 19 <b>66</b> , and that death occurred at <b>4/6/66</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>David L. Mossman</b>		22b. DATE SIGNED <b>4/6/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DAVID L. MOSSMAN M. D.</b>		22d. ADDRESS <b>MECHANICSVILLE, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>APRIL 8, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>TRINITY MEMORIAL GARDENS</b>	23d. LOCATION (City or Town) (County) (State) <b>WALDORF, CHARLES, MD.</b>
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>APR 11 1966</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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*Journal of Management Education* 26(8)

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WATERBURY, JUNE 20, 1904.

JAMES T. MOORE, JR.

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DOI: 10.1177/0886260505279001  
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THE CHAIRMAN, JAMES H. HARRIS, JR.

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1997 JAN 24 14 10 00

1995

CLARK, PAUL HENRY - BOMASTON, ARYLAND

229: 1 + 899

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05931 CERTIFICATE OF DEATH 05928											
1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Marys Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Great Mills</b> 18-1 d. STREET ADDRESS <b>Rural</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>CATHERINE</b> Middle <b>ANN</b> Last <b>ROBB</b>			4. DATE OF DEATH April 18 19 66		5. SEX <b>female</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/3/1898</b> 9. AGE (In years last birthday) <b>68</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>James B. Goldsborough</b>					14. MOTHER'S MAIDEN NAME <b>Catherine Norris</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Angus K. Robb - same as #2</b> Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure + pyelonephritis</b> 174X DUE TO (b) <b>Carcinomatosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Malignant Hypertension of the Uterus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (the hospital) attended the deceased from Aug 31, 1965, to April 17, 1966, that (I) (we) last saw the deceased alive on April 17, 1966, and that death occurred at 12:45 AM, from the causes and on the date stated above.											
22a. SIGNATURE <b>Samadi</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/18/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>Abdussamed Samadi, M.D.</b>					22d. ADDRESS <b>Leonardtown, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>4/21/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Our Lady's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Leonardtown, Maryland</b>				
24. FUNERAL DIRECTOR <b>P.B. Robinson</b> ADDRESS <b>P.B. Robinson - Leonardtown, Maryland</b>					25a. REC'D BY REGISTRAR <b>APR 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



05932

## CERTIFICATE OF DEATH

05929

1. PLACE OF DEATH a. COUNTY <u>Saint Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Saint Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patuxent River</u>				c. LENGTH OF STAY IN 1b <u>8 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lexington Park, Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Station Hospital, NAS, Patuxent River</u>				d. STREET ADDRESS <u>Box 107-142 Lexington Pk. Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>Thomas</u> Last <u>Ryan</u>				4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>19 66</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 15, 1960</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u>		IF UNDER 24 HRS. Hours <u>8</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Saint Mary's, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Martin Joseph Ryan</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Anna Mc Laury</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Martin J. Ryan</u> Address <u>Same as #2D</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>7735</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Prematurity</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Apr 15</u> , 19 <u>66</u> , to <u>Apr 23</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>23 Apr</u> 19 <u>66</u> , and that death occurred at <u>0819M, 4/23/66</u> from causes on and on the date stated above.							
22a. SIGNATURE <u>John P. Claherty</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>J. P. CLOHERTY LT MC USN</u>				22d. ADDRESS <u>Station Hospital, USNAS, Patuxent River</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANSIT</u>		23b. DATE THEREOF <u>4/25/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ALTAMONT, NEW YORK</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>E. B. ROBINSON - LEONARDTOWN, MARYLAND</u>				25a. REC'D BY REGISTRAR <u>APR 28 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4500



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05933

Item 7 Film G376 5/17/66 mh

CERTIFICATE OF DEATH

05930

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>		c. LENGTH OF STAY IN 1b <b>10 DAYS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CHAPTICO</b>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S HOSPITAL</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM JOHNSON SCOTT JR.</b>		4. DATE OF DEATH Month Day Year <b>APRIL 5 19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 2, 1890</b>
9. AGE (In years lost birthday) yrs. <b>75</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATERMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM J. SCOTT</b>		14. MOTHER'S MAIDEN NAME <b>ROSE WHEELER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS PEARL RUSSELL</b>		Address <b>AVENUE, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure - Cerebral edema</b> <b>493X</b> DUE TO (b) <b>Pneumonia</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/27, 1966</b> , to <b>4/5, 1966</b> that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>4/5</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Charles Greenwell</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES GREENWELL M. D.</b>		22d. ADDRESS <b>LEONARDTOWN, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 7, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>BUSHWOOD, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>		25a. REC'D BY REGISTRAR <b>APR 11 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

05330

05330

ST. MARY'S

WYLAND

ST. MARY'S

GENERAL CHARTER

10 DAY

LEONARD & Y

ST. MARY'S HOSPITAL

ST. MARY'S

WYLAND

WILLIAM

12

WYLAND

WHITE

WYLAND

12

WILLIAM J. BOOTE

ST. MARY'S HOSPITAL

ONE

10

ST. MARY'S HOSPITAL

CHARLES FRANKLIN

WYLAND

SACRED HEART CHURCH

APRIL 1, 1900

WYLAND

APR 11 1900

WYLAND

VR A15 (4)  
20M 1/65

6

## 05931

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>		c. LENGTH OF STAY in 1b <b>18-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Mary's Hospital</b>		d. STREET ADDRESS <b>RURAL LEONARDTOWN</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPH CHARLES WATHEN</b>		4. DATE OF DEATH Month Day Year <b>APRIL 20, 1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 2, 1887</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <b>78</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN H. WATHEN</b>		14. MOTHER'S MAIDEN NAME <b>REBECCA JOY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS VIOLET F. FLETCHER</b>		Address <b>LEONARDTOWN, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure Myocarditis</b> <b>1561</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) <b>Cancer of Lungs</b> OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/11</b> , 19 <b>66</b> , to <b>4/20</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/20/1966</b> , and that death occurred at <b>4 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles Greenwell</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES GREENWELL M. D.</b>		22d. ADDRESS <b>LEONARDTOWN, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 23, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. ALOYSIUS</b>		23d. LOCATION (City, town or county) (State) <b>LEONARDTOWN, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>		25a. REC'D BY REGISTRAR <b>APR 22 1966</b>	
ADDRESS <b>LEONARDTOWN, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1831

ST. MARY'S  
LEONARDTOWN  
ST. MARY'S HOSPITAL  
JOSEPH  
CHARLES  
MATHIAS  
APRIL 20  
OCTOBER 2, 1906  
WHITE  
FARMER  
LEONARDTOWN, MARYLAND  
REBECCA JAY  
MRS. VIOLET FLETCHER  
LEONARDTOWN, MARYLAND

CHARLES BRECKINRIDGE  
LEONARDTOWN, MARYLAND

BURIAL  
APRIL 23, 1906  
ST. LOUIS  
LEONARDTOWN, MARYLAND  
ATTORNEY LEONARDTOWN, MARYLAND  
APR 23 1906

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05935 CERTIFICATE OF DEATH 05932											
Item 9 Film 0375 4/14/66											
1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Morganza</u>					
c. LENGTH OF STAY IN 1b <u>1 hour</u>						d. STREET ADDRESS <u>18-1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Mary's Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Eleanor</u> Last <u>Yates</u>						4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>19 66</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 12, 1906</u>		9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>St. Mary's, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Benjamin Love</u>						14. MOTHER'S MAIDEN NAME <u>Annie May Graves</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>MR STEPHEN YATES</u>			Address <u>MORGANZA, MARYLAND</u>		
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Intoxication</u> <u>5811</u> DUE TO (b) <u>Cancers</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Alcoholism</u>										INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>  </u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>April 6, 1966</u> , to <u>April 6, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 6, 1966</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>David L. Mossman</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.O. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/6/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>David L. Mossman, M.D.</u>						22d. ADDRESS <u>Mechanicsville, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6/11/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Morganza, Maryland</u>		
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley, Leonardtown, Md.</u>						25a. REC'D BY REGISTRAR <u>APR 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

MR STEPHEN YATES ORGANZA, ARIZONA

APR 11 1963



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
05936  
CERTIFICATE OF DEATH  
05933

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Loveville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Marys Nurseing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Louise</b> Last <b>Young</b>				4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>19 66</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/15/1917</b>		9. AGE (In years last birthday) <b>48</b> yrs.	10. IF UNDER 1 YEAR Months <b>18</b> Days <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John H. Young</b>				14. MOTHER'S MAIDEN NAME <b>Rose H. Barnes</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Paul I. Young - same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> <b>4201</b> DUE TO (b) <b>Chronic Rheumatic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>less than 1 hr.</b> <b>2.5 years.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <b>John F. Fenwick</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/26/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>John F. Fenwick, MD</b>				22d. ADDRESS <b>Leonardtown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/29/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Morganza, Maryland</b>	
24. FUNERAL DIRECTOR <b>P.B. Robinson</b>				ADDRESS <b>P.B. Robinson - Leonardtown, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAY 2 1966</b>	
						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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